

GOVERNMENT OF ANDHRA PRADESH

ABSTRACT

Health & Family Welfare – Maternal & Child Health Division – Child Death Review - Implementation of the reviews in all the 13 districts of Andhra Pradesh – Operational guidelines and process - Orders – Issued.

HEALTH, MEDICAL AND FAMILY WELFARE (E.2) DEPARTMENT

G.O.MS.No. 54

Dated: 22-02-2017

Read:-

From the Commissioner of H & FW, A.P., Vijayawada,
Letter No.378/JD(CH&I)/2013-14, dt. 02/2017.

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ORDER:-

Globally maternal mortality ratio and infant mortality rate are two critical health indicators basing on which the performance of the country in the field of H & FW is assessed. India has done reasonably well in reducing the MMR & IMR currently at 110 per 1 lakh & 41 per 1000 live births respectively. The state of Andhra Pradesh is having an MMR & IMR of 92 per 1 lakh & 35 per 1000 live births respectively.

2. MMR is quantitatively and qualitatively being analysed by Maternal Death Review leading to corrective steps in the direction of reducing it, still further. Child Death Review also has to be done on the same lines as Maternal Death Review, which logically should lead to identify the quantum of the problem of Child Deaths, its causes, corrective steps to be taken at various levels to prevent them and ultimately leading to further decline in Child Mortality. Major contributions to Child Death are Neonatal Mortality Rate, Infant Mortality Rate and Under 5 Mortality Rate. In the state of Andhra Pradesh, they are presently at 25, 35 & 41 respectively.

3. Though the State of A.P. came a long way in reducing the IMR from 49 in 2010 to the present 35, it could not achieve the MDG of below 30. Likewise, much progress has not been made in the fields of NMR and under 5 MR also. For example - the present NMR of 25 has to reach 24 by 2017, 21 by 2020 and 15 by 2025. The SDG goals for NMR & under 5 mortality are 12 and 25 respectively.

4. To reduce child mortality, the need to assess the cause of death for each case assumes importance, leading an action plan which reflects in the strategies to improve child survival.

5. Government, after careful examination of the matter, hereby frame the following operational guidelines, to implement Child Death Reviews (CDR) in all the 13 districts of Andhra Pradesh:

I. The Process:

Child Death Review is a step in that direction, where in, all Child Deaths are reported, investigated in detail, arrive at the systemic causes and social determinants leading to death of the child, analyse those causes and point at actions to be taken at various levels through Public Health System or in Convergence with other sectors.

Child Death Review has to be in place, across the state as envisaged in the operational guidelines by the Child Health Division, MoHFW, GOI. Children in the age group of 0 to 5 years will be included in this review with all Deaths at home/Health facility/in transit, to be reported.

The review will be of two types namely, Community Based Child Death Review (CBCDR) & Facility Based Child Death Review (FBCDR). The processes of notification, investigation, data transmission and analysis followed by Action Plans for future are to be in place as per the operational guidelines by the Child Health Division, MoHFW, GOI.

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The flow charts and processes for CBCDR and FBCDR, attached as Annexures-I & II, shall follow the same procedures and guidelines outlined in this G.O and subsequent Communications issued in relation to MDR. Various Committees and Taskforces have to be formed with their TOR, Members, actions and time lines as mentioned in the Annexures-III,IV & V, attached to this G.O.

Roles and responsibilities of the Nodal Officers at Divisional level / Facility / District / State are to be strictly adhered to. CDR related trainings have to be Conducted at every level and from time to time. Monitoring of the same has to be done at every level. Formats stipulated in the guidelines only, need to be used.

II. The Objective:

Analysis of data by the District Magistrate on a monthly basis (along with MDR), is Critical for further Action Plan to be in place at District level in reducing the Child Mortality.

At the state level, the State level Task force shall review CDR (concurrently with MDR), duly identifying the social and cultural factors Contributing to:

- A. First Delay - In Decision making process at home
- B. Second Delay - In transportation, arranging funds / Logistics
- C. Third Delay - In Delivering services.

State Level Review has to be conducted once in a month, key decisions and action points should be circulated to all stakeholders in various departments with clear time lines for action and steps forward,

III. The Goal:

Ultimately each Child Death has to be reported without any fear of punitive action, accounted for, identifying the causes there of and putting the corrective steps in place at every level - to bring the child mortality to the expected level of achievement as per SDG.

6. The Commissioner of Health & Family Welfare, A.P., Vijayawada, shall take further action accordingly.

(BY ORDER AND IN THE NAME OF THE GOVERNOR OF ANDHRA PRADESH)

**POONAM MALAKONDAIAH
PRINCIPAL SECRETARY TO GOVERNMENT**

To:

The Commissioner of Health & Family Welfare, .A.P,
Gollapudi, Vijayawada.

Copy to :

All the members in State CDR Committee through
the Commissioner of Health & Family Welfare, .A.P,
Gollapudi, Vijayawada.

//FORWARDED::BY ORDER//

SECTION OFFICER

(Annexure to G.O.Ms.No.54, HM & FW (E.2) Dept., dt: 22.02.2017)

**ANNEXURE – I
CBCDR FLOW CHART**

State Level Task Force - Technical & administrative issues re-viewed with clear timelines for action & further steps

JD (CHI)- Prepares the State CDR report for presentation at the State Level Task Force meeting Conducted twice yearly

DM&HO- Reviews the Child deaths monthly in the DCDRC meeting and minutes sent to JD(CHI)	District Collector – Selected deaths are reviewed monthly in the presence of 2 family members of the deceased child.
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PHC, MO-Prepares the line list and selects the cases for detailed investigation. Copy of the verbal autopsy form sent to District Nodal Officer (Addl.DM&HO) within a week.	Investigators – Conduct the verbal autopsy of cases selected by PHC, MO and submit the report to DNO (Addl. DM&HO)
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ANM- Conducts the First Brief Investigation within one Week of death of the child and submits report to the PHC, MO within 15 days.

ASHA - Informs about child deaths (0-5 years) to the ANM and the PHC, MO. within 24 hours of death and fills the notification card within 48 hours

**POONAM MALAKONDAIAH
PRINCIPAL SECRETARY TO GOVERNMENT**

(Annexure to G.O.Ms.No. 54, HM & FW (E.2) Dept., dt: 22.02.2017)

**ANNEXURE-II
FBCDR FLOW CHART**

State Level Task Force – Technical & Administrative issues re-viewed with clear timelines for action & further steps.

JD (CHI) – Prepares the State CDR report for presentation at the State Level Task Force meeting conducted twice yearly.

DM&HO – Reviews the child deaths monthly in the DCDRC meeting and minutes sent to JD (CHI)	District Collector – Selected deaths are reviewed monthly in the presence of 2 family members of the deceased Child
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FNO / HOD, Paediatrics / Paediatrician – all Child deaths reviewed by the FBCDR committee every month and reports sent to the District Nodal officer (Addl. DM&HO) every month.

On duty MO / Paediatricians / MO, who attended the case – Informs the Medical Superintendent immediately about the child death in facility and fills the notification card within 24 hours and conduct the detailed investigation within 48 hours of death

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ANNEXURE - III
Child Death Review Committees

FBCDR Committee

FBCDR Committee may have the following members

Teaching Hospital:

Hospital superintendent/other administrative head of the institution Head of the Pediatrics Dept.

Facility Nodal Officer (Pediatrician)

At least two members from the Pediatrics Dept. (Pediatrician/MO posted in the dept.)

One Anesthesiologist

Nurse posted in Pediatrics Dept.

District/Other Hospitals:

Hospital superintendent

Facility Nodal Officer (Pediatrician)

Pediatrician/Medical officer posted in the Pediatrics

One Anesthesiologist

Nurse posted in Pediatrics

FBCDR Committee:

The committee meets once every month. Facility Nodal Officer (Pediatrician) fixes the meeting in discussion with the Hospital superintendent

The main focus of the review is to check the clinical protocols and the line of treatment followed

FBCDR formats and Case summary will be discussed in the review meeting
Suggests corrective measures and steps to be taken to improve quality of care at the hospital

Suggests steps to be taken at the District level and State level

Sends minutes of the meeting to the DNO (Addl. DM&HO) along with the case summary prepared.

POONAM MALAKONDAIAH
PRINCIPAL SECRETARY TO GOVERNMENT

ANNEXURE - IV

District Child Death Review Committee

The DNO (Addl. DM&HO) will be selecting a total of 6 cases (including both CBCDR and FBCDR) for review at the DCDRC meetings. He will take into account the following criteria for selecting Cases.

1. Cause of death
2. Place of death (home, facility, in transit)
3. Age (neonatal, post-neonatal, child)
4. Sex
5. Children from Vulnerable groups
6. Clustering of cases (if any)

The District MDR Committee should be assigned the responsibility of reviewing Child Death Reports as there are inter-linkages between maternal and neonatal deaths and the indirect causes are likely to be the same in many cases. Additional members may be brought on the same committee for review of child deaths and the following composition is suggested

Members

1. Chief Medical Officer/Civil Surgeon (Chairperson)
2. Additional Chief Medical Officer
3. District Nodal Officer (Member Secretary)
4. Paediatrician
5. Obstetrician/Gynaecologist
6. Anesthesiologist
7. Senior Nurse nominated by the CMO/CS
8. Medical Officer who had attended the case in the facility
9. District Project Officer for ICDS
10. Representative/s from recognised professional bodies (Indian Academy of Paediatrics, National Neonatology Forum, IAPSM)
11. Experts from medical college/development agency (if present in the district)
12. Any other official or person deemed important for providing specific technical inputs (at the discretion of the Chairperson)

All FNOs (Paediatricians) and MOs (Concern with the cases) should be invited to attend this meeting.

The CDR meeting should be Conducted simultaneously with the MDR meeting, which is Supposed to take place every month, with the purpose of reviewing the causes and trends of child deaths in the district. The Action Taken Reports, the minutes of the last meeting should be reviewed by the Chairperson.

The DCDRC should undertake the task of identification and discussion on the modifiable factors contributing to child deaths at the community and facility level and come up with recommendations for short term, medium term and long term implementation. The DNO should bring together the recommendations made by members of the DCDRC and convert it into an actionable plan.

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At the end of the DCDRC meeting, CMO in consultation with the DNO will select 3 cases (including CBCDR, FBCDR) for review by the District Magistrate.

District Magistrate (DM) review meetings of CDR

A sample of child deaths reviewed by the DCDRC will be put up for the DM review. This sample will be chosen in accordance with the selection criteria explained before. The DM has the option to select any case which is reported in a month and also to review more than 3 Cases if he chooses to.

This review will be attended by the following members.

1. District Magistrate - Chairperson
2. Chief Medical Officer
3. District Nodal Officer
4. Facility Nodal Officers AP representative

The parents/relatives (max. 2 persons) of the deceased child would be invited for the meeting by the DNO. The service providers (in case of FBCDR) who had attended the child Will also be called for this meeting. To cover the expenditure incurred by the family of the deceased child on a CCount of travel to the district headquarters a sum of Rs. 200/- should be given to the family.

The parents/relatives of the deceased child will first narrate the events leading to the death of the child, in front of the DM and the service providers who attended the deceased child. The Case history of each of the selected child deaths will be heard separately. After the deposition and getting clarifications from the relatives they will be sent back. Then the various delays - the decision making at the family, getting the transport and institutional delays would be discussed in detail. The outcome of the meeting will be recorded as minutes and Corrective actions will be listed with a time line to prevent similar delays in future.

The DM will try to ensure the release of necessary resources and providing an enabling environment for implementation of the key recommendations emerging from the meeting. In addition the DM should be able to promote inter-sectoral co-ordination in order to bridge the gaps falling in non-health sectors such as nutrition, safe drinking Water, Sanitation and so on.

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(Annexure to G.O.Ms.No. 54, HM & FW (E.2) Dept., dt: 22.02.2017)

ANNEXKURE - V
State Level Task-force:

The State Level Task-force constituted for the review of maternal deaths (with additional members co-opted as listed below) will review the CDR process. The meeting of the task-force is to be convened every 6 months. The task-force may review both maternal and child deaths at the same time or schedule it on different days. The inter linkages between the maternal and neonatal causes of death should be explored and a common set of recommendations be made to prevent them. The data from the districts compiled at the state level should be reviewed and trends observed and analyzed. DNOs should be invited to attend this meeting. The Action Taken Report on the Minutes of last meeting of the State Task-force should be presented by the SNO. Minutes of the meeting should be put on record. Key decisions and action points should be circulated to all stakeholders in various departments with clear time lines for action and steps forward.

Members:

1. Principal Secretary Health & Family Welfare.
2. State Mission Director NHM.
3. Commissioner of Health & Family Welfare.
4. Director Of Health Services.
5. State Nodal Officer (JD CHI)
6. Pediatricians and Public Health Experts from State Govt and Private Medical Colleges (max 3)
7. Obstetric Specialists from State Govt. and Private Medical Colleges (max. 1)
8. State ICDS Officer (JD (ICDS), WD & CW Dept.)
9. Deputy Director/Director Nursing
10. Deputy Director/Director MSD (materials/supplies and disposables)
11. IAP representative
12. Any other expert, official, person deemed important for discussion on a particular issue (at the discretion of the Chairperson)

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